Comments on Rosenshein and Valentine, "The Role of Primary Care Providers in Mental Health Care" A Literature Review Submitted to the Myers-JDC-Brookdale/Brandeis Collaboration on Mental Health

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Family physicians have always treated the mentally ill. Nevertheless, I am not convinced that primary/family physicians ought to be the main care provider or manager of patients suffering from severe, chronic mental illness, or replace the psychiatrists.

The article describes various models most of which have been tried experimentally in research but which, when applied on a daily basis, encountered insufficient resources. In my opinion, any model that situates the mental-health patient at the center is a good one that will facilitate better care, a better response to treatment, and avoid hospitalization. My response will relate to the three main models described in the article: coordinated, collaborative, and integrated - each one is good and there is room to use all the models depending on the possibility and the location, on condition of cooperation between mental-health staff and primary-clinic staff.

As regards the situation in Israel, the reform, and the context of these models: I would like to stress that the reform applies to mental health, not to family medicine, and its main goal is to transfer the care of the mentally ill – which was the responsibility of the Ministry of Health – to the responsibility of the HMOs. To this end, the HMOs should prepare infrastructure for mental-health clinics with a staff of psychiatrists, psychologists, and social workers, and locate the staff either in primary clinics with the family physicians, or in HMO specialized clinics. I believe that for family physicians, psychiatry should be one more category of specialist consultation, much like cardiology or neurology for example, with the stigma removed. Family physicians have always treated the mentally ill, whether for a diagnosis and treatment in the case of soft psychiatry – especially for depression, anxiety, panic attacks – or for follow-up together with psychiatrists of patients suffering from schizophrenia, bipolarism or severe obsession, who were treated mainly by psychiatrists and the help of family physicians for follow-up (including the need for blood tests to monitor the various psychiatric drugs). The difference today is that the work has to be done with the psychiatric staff at an HMO rather than at the Ministry of Health, but under no circumstances should family physicians replace psychiatrists.

In some areas of Israel, such as the northern district of Clalit Health Services, psychiatric services have been implemented for years using all the models.

1. *Coordinated model – mentally ill patients are referred to the large external clinic at the Emek Medical Center or to scattered mental health clinics throughout the district. Some of the family physicians were in contact with psychiatrists, whether at the*

initiative of family physicians or of the psychiatrists who made sure to produce clear, detailed letters of summary.

2. *Integrated model – Psychiatrists are posted on location in primary clinics.*
3. *Collaborative model – This was used mainly at teaching clinics back in the 1980s; patient cases were presented by a family physician to a senior psychiatrist who provided consultation on the treatment and on the patients who were to be referred directly to mental-health clinics.*

As noted, in my opinion there is room for all the models if the following basic conditions are maintained:

1. *Psychiatric consultation should be available and accessible, and the waiting time should be reasonable. A situation of insufficient psychiatrists and protracted waiting time is unacceptable since the poor would be referred to family physicians, who in Israel are available and accessible to an unlimited degree whereas the rich would turn to psychiatric consultation, either privately or through supplementary insurance.*
2. *The number of annual visits to a psychiatrist should on no account be limited; limits were suggested in one of the amendments proposed to the National Health Insurance Law.*
3. *Psychologists or social workers must be available and accessible. The number of annual therapy visits can be limited as is done in physiotherapy.*
4. *There must be two-way collaboration between psychiatrists and family physicians in every model and the exchange of vital information about treatment unless the patient refuses.*
5. *Before the reform, patients were able to apply directly to psychiatric consultation rather than go through their family physician – this option should be left in place.*
6. *Some choice should be allowed regarding psychiatric wards and hospitals.*
7. *I am not of the opinion that family physicians should treat the mentally ill instead of psychiatrists. Family doctors are not psychiatrists, just as they are not cardiologists. However, some of the follow-up can be done by family physicians, especially of the lighter cases of "balanced" patients.*

Regarding the connection between physical and mental illnesses of the mentally ill, I do not accept the contention that treatment of their physical illnesses (such as elevated cardiovascular risk among schizophrenics, depression after cardiac arrest, etc.) necessarily comes at the expense of the treatment of their mental illnesses. I think that both primary care physicians and psychiatrists need to treat the whole patients, each from his/her own perspective, and close operation between them will contribute to efficient and optimal care.